General

Guideline Title

Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer.

Bibliographic Source(s)

Lieberman DA, Rex DK, Winawer SJ, Giardiello FM, Johnson DA, Levin TR. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology. 2012 Sep;143(3):844-57. [85 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Winawer SJ, Zauber AG, Fletcher RH, Stillman JS, O'Brien MJ, Levin B, Smith RA, Lieberman DA, Burt RW, Levin TR, Bond JH, Brooks D, Byers T, Hyman N, Kirk L, Thorson A, Simmang C, Johnson D, Rex DK. Guidelines for colonoscopy surveillance after polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer and the American Cancer Society. Gastroenterology 2006 May;130(6):1872-1885. [83 references]

Recommendations

Major Recommendations

Definitions for the quality of evidence (high, moderate, low, very low) are provided at the end of the "Major Recommendations" field.

2012 Recommendations for Surveillance and Screening Intervals in Individuals with Baseline Average Risk

Baseline Colonoscopy: Most Advanced Finding(s)	Recommended Surveillance Interval (years)	Quality of Evidence Supporting the Recommendation	New Evidence Stronger than 2006
No polyps	10	Moderate	Yes
Small (<10 mm) hyperplastic polyps in rectum or sigmoid	10	Moderate	No
1–2 small (<10 mm) tubular adenomas	5-10	Moderate	Yes
3–10 tubular adenomas	3	Moderate	Yes
>10 adenomas	<3	Moderate	No

Baseline Colonoscopy: Most Advanced Finding(s)	Recommended Surveillance Interval (years)	Quality of Evidence Supporting the Recommendation	New Evidence Stronger than 2006
One or more tubular adenomas ≥10 mm	3	High	Yes
One or more villous adenomas	3	Moderate	Yes
Adenoma with high grade dysplasia (HGD)	3	Moderate	No
Serrated lesions			
Sessile serrated polyp(s) <10 mm with no dysplasia	5	Low	NA
Sessile serrated polyp(s) ≥10 mm OR Sessile serrated polyp with dysplasia OR Traditional serrated adenoma	3	Low	NA
Serrated polyposis syndrome[a]	1	Moderate	NA

Note: The recommendations assume that the baseline colonoscopy was complete and adequate and that all visible polyps were completely removed.

NA, not applicable

[a]Based on the World Health Organization definition of serrated polyposis syndrome, with one of the following criteria: (1) at least 5 serrated polyps proximal to sigmoid, with 2 or more ≥10 mm; (2) any serrated polyps proximal to sigmoid with family history of serrated polyposis syndrome; and (3) >20 serrated polyps of any size throughout the colon.

Recommendations for Polyp Surveillance after First Surveillance Colonoscopy

The Task Force believes that patients with low-risk adenomas (LRA) at baseline and negative findings at first surveillance can have their next surveillance examination at 10 years. Patients who have high-risk adenomas (HRA) at any examination appear to remain at high risk and should have shorter follow-up intervals for surveillance. A summary of these recommendations is outlined in the table below.

Baseline Colonoscopy	First Surveillance	Interval for Second Surveillance (years)
Low-risk adenomas (LRA)	HRA	3
	LRA	5
	No adenoma	10
High-risk adenomas (HRA)	HRA	3
	LRA	5
	No adenoma	5[a]

[a]If the findings on the second surveillance are negative, there is insufficient evidence to make a recommendation.

Definitions:

Levels of Evidence

Rating of Evidence	Impact of Potential Further Research
High quality	Very unlikely to change confidence in the estimate of effect
Moderate quality	Likely to have an important impact on confidence and may change estimate of effect
Low quality	Very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate
Very low quality	Any estimate of effect is very uncertain

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Colorectal cancer (CRC)

Guideline Category

Diagnosis

Prevention

Risk Assessment

Screening

Clinical Specialty

Colon and Rectal Surgery

Family Practice

Gastroenterology

Internal Medicine

Oncology

Preventive Medicine

Intended Users

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Physician Assistants

Physicians

Public Health Departments

Guideline Objective(s)

To issue an updated set of colonoscopy surveillance recommendations based on new evidence that has emerged since the US Multi-Society Task Force on Colorectal Cancer 2006 recommendations

Note: This guideline does not address surveillance after colonoscopic or surgical resection of a malignant polyp.

Target Population

Asymptomatic people with adenomatous polyps detected by colorectal screening

Note: Patients with inflammatory bowel disease or prior history of colorectal cancer (CRC) are excluded. This guideline applies to average-risk individuals and excludes patients with hereditary syndromes associated with CRC.

Interventions and Practices Considered

Colonoscopy surveillance intervals after initial screening and polypectomy based on risk assessment

Major Outcomes Considered

The relationship between baseline examination findings and the detection of colorectal cancer (CRC), advanced adenoma, or any adenoma during the follow-up period

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The guideline task force performed a MEDLINE search of the postpolypectomy literature under the subject headings of colonoscopy, adenoma, polypectomy surveillance, and adenoma surveillance, limited to English language articles from 2005 to 2011. Subsequently, additional articles were gleaned from references of the reviewed articles. Relevant studies include those in which outcomes addressed the relationship between baseline examination findings and the detection of colorectal cancer (CRC), advanced adenoma, or any adenoma during the follow-up period. Studies used in the final analysis are summarized in Table 2 in the original guideline document by specific category. The task force also reviewed studies with results of more than one surveillance examination to determine the downstream risk that may be associated with the baseline findings. A key goal was to determine if the risk of subsequent neoplasia was reduced once a patient had negative findings on colonoscopy or had low-risk adenomas. The task force excluded studies that included patients with inflammatory bowel disease or prior history of CRC. This review applies to average-risk individuals and excluded patients with hereditary syndromes associated with CRC.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Rating of Evidence	Impact of Potential Further Research
High quality	Very unlikely to change confidence in the estimate of effect
Moderate quality	Likely to have an important impact on confidence and may change estimate of effect
Low quality	Very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate
Very low quality	Any estimate of effect is very uncertain

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

There are no high-quality randomized controlled trials of polyp surveillance performed in the past 6 years. All studies are either retrospective or prospective observational, cohort, population-based, or case-control studies. The task force has adopted a well-accepted rating of evidence that relies on expert consensus about whether new research is likely to change the confidence level of the recommendation (see the "Rating Scheme for the Strength of the Evidence" field).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Process

The task force is composed of gastroenterology specialists with a special interest in colorectal cancer (CRC), representing the 3 major gastroenterology professional organizations: American College of Gastroenterology, American Gastroenterological Association Institute, and American Society for Gastrointestinal Endoscopy. The task force recognizes that inherent bias can be introduced when a group of experts in the field review evidence and provide recommendations. In addition to the task force, the practice committees of the American Gastroenterological Association Institute and the American College of Gastroenterology and the governing board of the American Society for Gastrointestinal Endoscopy reviewed and approved this document.

Format of the Report

The report includes statements that summarize new, relevant literature since 2005. This is followed by recommendations for surveillance based on the most advanced finding of the baseline colonoscopy examination. For each baseline finding (or lack of finding), there is a recommendation, background section, summary of new evidence since 2006, and discussion of unresolved issues and areas for further research.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

In addition to the task force, the practice committees of the American Gastroenterological Association Institute and the American College of Gastroenterology and the governing board of the American Society for Gastrointestinal Endoscopy reviewed and approved this document. Although not noted in the guideline, the guideline was also approved by the American Gastroenterological Association Institute Governing Board.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

There are no high-quality randomized controlled trials of polyp surveillance performed in the past 6 years. All studies are either retrospective or prospective observational, cohort, population-based, or case-control studies.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Interval examinations may prevent interval cancers and cancer-related mortality
- During the past 6 years, new evidence has emerged that endorses and strengthens the 2006 recommendations. The task force believes that a stronger evidence base will improve adherence to the guidelines.

Potential Harms

There is considerable new evidence that the risk of colonoscopy increases with advancing age. Both surveillance and screening should not be continued when risk may outweigh benefit.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Identifying Information and Availability

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 May (revised 2012 Sep)

Guideline Developer(s)

U.S. Multi-Society Task Force on Colorectal Cancer - Clinical Specialty Collaboration

Source(s) of Funding

Not stated

Guideline Committee

U.S. Multi-Society Task Force on Colorectal Cancer

Composition of Group That Authored the Guideline

Task Force Members: David A. Lieberman; Douglas K. Rex; Sidney J. Winawer; Francis M. Giardiello; David A. Johnson; Theodore R. Levin

Financial Disclosures/Conflicts of Interest

The authors disclose the following: David A. Lieberman is an advisory board member for Given Imaging and Exact Sciences. Douglas K. Rex is an

advisory board member for Given Imaging and has received research funding from Olympus Corp. David A. Johnson is a clinical investigator for Exact Sciences and an advisory board member for Given Imaging. The remaining authors disclose no conflicts.

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Guideline Availability

Electronic copies: Available from the Gastroenterology Web site .

Availability of Companion Documents

An audio Podcast for this guideline is available on the Gastroenterology Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on February 4, 2008. The information was verified by the guideline developer on February 29, 2008. This summary was updated by ECRI Institute on November 27, 2012. The updated information was verified by the guideline developer on December 21, 2012.

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